The Place and Training of the General Practitioner

WARD DARLEY, M.D., *Denver*

SUMMARY

Training for the medical student whose goal is general practice should aim at equipping him to maintain the close personal relationship with the patient which is considered the ideal basis for the treatment and prevention of disease. Preparation for general practice should anticipate graduate experience on a par with that which is currently considered necessary for the various specialties. Internship should be such as to fit the general practitioner to the peculiarities of the kind of community in which he will practice. Ability to recognize his own limitations and situations in which special consultation or referral are indicated should be developed in the student.

The University of Colorado School of Medicine has adopted a course of training, from pre-medical education through internship, designed for the student who is to specialize in general practice.

REASONABLY effective medical care is dependent upon a proper balance between medical information and the ability to put this information into actual service. Today, with medical knowledge accumulating as never before and with powerful factors operating to alter the social and economic setting in which medical service must be rendered, the medical profession is faced at the same time with complex problems and tremendous responsibilities.

It is axiomatic that good medical care will parallel high standards of medical education. For this axiom to hold, however, the term "medical education" must be used to denote an active process that concerns the entire period of the physician's professional activity—not just his years of basic professional preparation. The rapid and complex changes now taking place in and around medicine and its practice should create a powerful challenge to all who are interested in medical education and its complicated relationship to medical care. For some time now the time has been at hand for a reevaluation of the aims of medical education and the development of a philosophy of education and of curricula that are consistent with these aims.

From the Office of the Dean, University of Colorado School of Medicine.

Presented before the Special Meeting on Postgraduate Training and Medical Economics, at the 77th Annual Meeting of the California Medical Association, April 11-14, 1948.

Since the end of the war, Colorado has been attempting to do just this. The term "Colorado" is used broadly because the effort represents activities not only of the School of Medicine but of the state government, the medical societies, the hospital association, voluntary health organizations and many other units and interests in the state-wide community. While some of the thinking has taken root from suggestions contained in the literature, particularly the Weiscotten report[3] and Allen's *Medical Education and the Changing Order*,[1] much of it has developed as the result of our own observation of our own faults and problems and as the result of our own estimates of our own resources and responsibilities.

Walter Bauer has said that it is too bad that all individuals with "M. D." after their names are not physicians. While the qualities that make for the true physician are, in all probability, inherent in the individual and hence the original selection of the student for medicine is of the first importance, we feel that, nevertheless, the educational processes should do everything possible to develop and stimulate the expression of those qualities and abilities that are essential. In developing curricula that attempt to do this, we feel that the tendency for medical care to become less personal than it used to be is constituting a definite handicap. Doctors now tend to concentrate in the larger towns and cities. Roads are good; automobiles are comfortable and fast; consequently, more and more the patient comes to the doctor instead of the doctor going to the patient. The average physician sees many more patients in a day than he used to. As a result the time per patient is reduced at the expense of the patient-physician relationship. Doctors are joining together in groups and clinics. Patients are hospitalized whenever possible, even for minor illnesses. Interns or junior men take patients' histories, frequently do the physical examinations, make most of the night calls and often substitute or alternate with the "chiefs" on daytime home and hospital calls. Nurses, technical personnel and machines and gadgets play an increasingly more prominent part in patient contacts. Thus, from the patient's standpoint, his contacts with the doctor—his doctor—are becoming more and more dilute and less and less personal. While insurance plans of one kind or another which provide for medical care may be filling a definite need, I cannot help feeling that this type of medical care adds to the depersonalization of medicine. I also feel that medical care provided through health services, such as are developing in industry, schools and governmental agencies, is an impersonal proposition. In fact, I feel that anything

that detracts from the direct mutual responsibility between doctor and patient, as is the case when a third party pays the bills, is detrimental to the patient-physician relationship.

The development of specialism is playing an important part in depersonalizing medical practice. I recognize that the tremendous acquisition of medical knowledge has made specialism inevitable and necessary. Specialism has been productive of much good and is here to stay. I submit, however, that most specialists are primarily oriented to pathology and to patients with unusual and complicated problems. Preventive medicine and the continued care of the patient are not characteristic of specialty practice. The approach is to a part of, rather than to the total, patient. Because most of the clinical teaching in our medical schools has been and is being done by specialists and because the average medical school hospital and clinic provides an impersonal type of medical care, the educational experience of the average medical student is such that too little emphasis is placed upon the patient as a total human being. As a rule, little happens to stimulate the student's interest in the maintenance of health and the prevention of disease. His orientation is basically to the diagnosis and treatment of disease entities. His interest in the prevention of chronicity and disability is lukewarm to say the least. His teachers, for the most part, are specialists; and the courses, clinics and clinical services are organized around the specialties. Many individuals and departments take part in the patient's total care. The patient does not necessarily see the same doctor or medical student twice in succession, and as far as the doctor or the medical student is concerned, there is very little continuity or patient responsibility.

To me, one of the main reasons for the progress and success of American medicine has been the principle of the personal and intimate nature of the patient-physician relationship. I feel that the depersonalization of medicine which is gradually taking place may prove to be a serious threat to American medicine's effectiveness. I cannot conceive of a satisfying type of well-balanced medical care developing out of a system that is not based upon the activities of a physician who is not only interested in filling the gap between the patient as a person and his occasional needs for a specialist, but who is qualified to do so as well. In other words, I feel that the general practitioner, or his equivalent, should play the dominant role in any program of comprehensive medicine. There are many who disagree. Most of those in disagreement point to the internist as the one who should be concerned chiefly with the very personal consistent type of care which most of our people need and desire. If this is to be so, the training of the internist will have to be much different from what it is today.

Be this as it may, we in Colorado think that there will always be a need for the general and very personal physician and that whether it be general practitioner or internist, his training must be such as to prepare him for a special job. The general practitioners are with us. They are the physicians who are closest to our people, and we feel that they are the ones to be developed so that they can maintain the key position in our scheme of medical care. We feel that our educational institutions should give consideration to the place which the general practitioner should play in our scheme of medical care and that his education and training should be provided for adequately.

In line with this reasoning, we feel that the basic training of all medical students up to and through the internship should be as if general practice were the only goal. Given an undergraduate and intern experience limited to the needs of general practice, we feel that an additional period of graduate or residency training is necessary if the general practitioner is to function as he should. This idea is well expressed by Jensen[2] in a recent paper.

A short discussion of what we feel is the developing field of the general practitioner may serve to clarify his educational needs. This doctor—a physician in the fullest sense of the word—should be interested in and qualified to function as a health counsellor and a health coordinator for a given individual from birth to death. Personal preventive medicine, as well as community health, should claim a great deal of his effort. Ability to function effectively in the prevention, early diagnosis and treatment of emotionally and personality determined illnesses should be of the first importance. General diagnostic ability predicates that he will recognize his limitations and know when specialist consultation or referral is indicated. The need for proficiency in the therapeutics of the common medical conditions should be apparent. His need for surgical ability other than diagnostic will depend upon the locale of his practice and his proximity to surgical consultants and facilities. This physician should take particular interest in the prevention of chronicity and disability and should be keen to guide his patients to an active program of rehabilitation whenever indicated. What I have been describing is Dr. Lester Evans' concept of "the continuing care of the ambulatory patient." The physician who succeeds in this area will be the one who is adequately trained for the job.

The foregoing outlines the background reasoning of our efforts to emphasize the training of men and women for general practice. As already intimated, our effort begins with the freshman year in medical school. Very briefly, the undergraduate curriculum is first concerned with presentation of medicine as human biology: the normal development, structure and function of the individual human being's physique and personality and his reactions and methods of adaptation to the environment in which he has to live. An attempt is made to stimulate a reasonable interest in medical sociology and in personal and community preventive medicine. The student is brought into frequent contact with patients as total human beings throughout the freshman and sophomore years. The transition from medicine as human biology to human biology as medicine begins in the

sophomore year, so that the last two years of the undergraduate experience can emphasize a general type of clinical training. During this period the student is given the opportunity to accept a prolonged period of supervised patient responsibility that is carried into the home, as well as through the out-patient clinic and hospital. Detailed specialty procedures and techniques are not emphasized.

In my opinion, the average internship as an educational experience is far from satisfactory. Space does not permit a detailed discussion of criticisms, but I will mention the three that are in line with this paper: (1) The intern does not take an active enough part in the day-to-day care of patients, (2) his experience has little to do with the care of ambulatory patients, and (3) he sees too much emphasis placed upon specialty techniques and procedures. I feel that too many hospitals utilize interns as "cheap help" to the total disregard of the intern and the theoretical reasons for the internship. The aims of the internship should be reviewed by a responsible body, all internships should be reevaluated and all hospitals that cannot qualify in the light of this reevaluation should discontinue their intern programs. The internship at the Colorado General and Denver General hospitals has been reorganized with the idea of obviating the above criticisms.

I have mentioned before that the basic training of all medical students up to and through the internship should be as if general practice were the only goal. I feel the time is at hand when we must realize that the four years of medical school and an additional year of internship will no longer qualify a physician to assume responsibility for a reasonably safe and effective independent professional activity. This preliminary training, therefore, should be looked upon as a prerequisite for graduate work, regardless of the field in which the graduate work is to be done. Preparation for general practice should be anticipated as graduate experience on a par with that which is currently considered necessary for the various specialties. Since the general practitioner in our mountain or desert areas may be required to function differently from one in a large city, the organization and conduct of our general practice graduate program is individualized to accommodate our local problems. This is in line with our philosophy that the work and program of every medical school should be oriented to the community it serves.

We have just established a department of general practice, headed by a well-qualified general practitioner. This department will be responsible for the admission examination of all patients entering our clinic or hospital system. Reference to specialty clinics will depend upon this careful admission examination. Clinics in general medicine and surgery will be operated by this department, and members of the general practice staff will share in the care of patients upon the medical and pediatric wards. Conversely, our specialty departments cooperate in the general practice training program by accepting the residents for specified periods of time. An attempt is made to individualize these assignments to meet the needs of our concept of general practice. All our residents, regardless of the field in which they are being trained, are registered in the clinical division of the graduate school and are encouraged to work toward graduate degrees.

As the result of cooperation with the Colorado State Medical Society and the Colorado State Hospital Association, arrangements have been made for the general practice residents to spend the last six months of their three-year program in qualified rural hospitals. The Committee on Medical Education and Hospitals of the Colorado State Medical Society has set up the minimal standards for rural hospital participation and will take care of the necessary inspection, certification and supervision. Teams of teaching physicians will visit these hospitals at regular intervals. The organization and supervision of this activity will also be the responsibility of the Medical Society committee.

With this as the setting for our residency in general practice, the three-year program is described briefly as follows:

The program is arranged so that each year-unit need not occur in any definite relationship to another.

One Year:

Medicine—eight months. (During this period a series of well-organized symposia and seminars is conducted with the idea of providing a practical review of the applied sciences basic to medicine. Psychosomatic medicine is particularly stressed.)

Pediatrics—four months (including work in the out-patient department).

Another Year:

Obstetrics and gynecology—five months (including work in the out-patient department).

Public Health—one month.

Assignment to rural hospital—six months.

Another Year:

Surgery—12 months (divided equally into four-month periods: fractures, emergency operations and ward assignments).

It should be noted that our department of psychiatry maintains a psychiatric service which limits its activities to the medical, surgical, pediatric and obstetric wards of our general hospitals. All our interns and residents are encouraged to evaluate every patient from the personality and emotional standpoint and to see that psychosomatic problems receive proper therapeutic attention. The psychiatric staff assigned to the general hospitals provides the supervision essential to this activity.

As soon as we began to receive applications for our general practice residency, we were struck with the frequency with which the applicants indicated that they did not desire surgical training other than that which was diagnostic, and that in its place they desired more training in general medicine. This has pleased us very much, as it is our feeling that in the

not too distant future the average general practitioner will not be doing surgical operations or handling obstetrical cases. Consequently, we have provided an alternate third year so that those residents who do not desire the surgical training and rural hospital assignment may take additional training that is non-surgical in nature:

Alternate Third Year:

Psychosomatic medicine—three months.
General out-patient medicine—three months.
Physical medicine—one month.
Industrial medicine—one month.
Pediatric out-patient—three months.
Public health—one month.

Our general practice residency program is in the third year of its development. As would be expected, our ideas and approach are frequently changing as we manipulate the program. Consequently, there must be no surprise if what I have described above should be changed in the next few months. As of July 1, 1948, there were 14 general practice residents in training, and we hope that by 1951 we will be able to support a set-up which will carry approximately two to three times this number.

In order to complete the picture for the training of the general practitioner, postgraduate education obviously deserves consideration. We have been gratified by the increasing demand on the part of the general practitioners of our community for postgraduate work. It is well recognized that the best medicine is practiced where medicine is being taught. Consequently, we subscribe to the principle that we should integrate as many teaching physicians into our activities as possible. The participation of the staffs of rural hospitals in our residency training program is of the first importance in this regard. The stimulation which these staffs will receive from teaching residents and from the periodic visits of teaching teams constitutes excellent extramural postgraduate training.

At the request of our general practitioners, we are developing short refresher courses which cover specialty fields from the general practitioner standpoint. A recent one in obstetrics and gynecology was particularly successful. The course lasted two days. Five to ten minutes was taken by a competent teacher to present just one practical point. This was frequently followed by a demonstration and always by a general question and discussion period, following which another single consideration was taken up in a similar manner. This rapidly moving type of instruction very largely eliminated the fatigue common to the usual lecture type of program.

General practitioners are also coming to us with the request that arrangements be made for them to take individualized periods of training in some particular field. For example, one general practitioner has just finished spending six months with our division of psychosomatic medicine, and another is currently taking the same training. Many general practitioners are regularly spending from a half to a full day in our clinics as special students.

I am glad to know that a special committee of the California State Medical Society, with a salaried part-time chairman, is giving special consideration to the problem of developing a postgraduate program for its members in general practice, and we in Colorado will be most interested to compare notes from time to time.

The training of general practitioners is intimately tied up with the broad problems of medical care. A well-balanced system of medical care, whether it be urban or rural or depend upon group or individual practice, should in our opinion, hinge upon the physician who is qualified to take continuing responsibility for the individual patient. This physician, actively interested in preventive medicine, capable in diagnosis and appreciative of his limitations, can certainly fill an assignment that can be looked upon as one that is just as dignified and honorable as that filled by any specialist. This physician's most important job should be to keep his patient well and to make hospitalization as infrequent a necessity as possible. When serious or disabling illness strikes in spite of his efforts, he is the one to follow the patient, if necessary with the help of specialists, and to continue with his observation through the convalescent period with the aim of minimizing the chances of relapse, chronicity or disability. We should all realize that his maximum effectiveness will depend upon training and skill comparable to, if not greater than, that necessary for the practice of any of the specialties.

4200 East Ninth Avenue.

REFERENCES

1. Allen, R. B.: Medical education and the changing order, The Commonwealth Fund, New York, 1946.

2. Jensen, F.: The general practitioner needs a good education, too, Modern Hospital, 68:90 (June), 1947.

3. Weiscotten, H. G., Schwitalla, A. M., Cutter, W. D., and Anderson, H. H.: Medical education in the United States, Chicago, The American Medical Association, 1940.